AMENDED IN ASSEMBLY MAY 14, 2003

AMENDED IN ASSEMBLY APRIL 28, 2003

AMENDED IN ASSEMBLY APRIL 10, 2003

CALIFORNIA LEGISLATURE—2003–04 REGULAR SESSION

ASSEMBLY BILL No. 910

Introduced by Assembly Member Diaz

February 20, 2003

An act to amend Sections 1255.1 and 1300 of, and to add Division 112 (commencing with Section 130500) to, the Health and Safety Code, relating to hospital community responsibility.

LEGISLATIVE COUNSEL'S DIGEST

AB 910, as amended, Diaz. Hospitals: service changes: ownership.

Existing law generally establishes requirements for the construction, closure, and operation of acute care hospitals.

Existing law also provides generally for the licensure and regulation of health facilities, including general acute care hospitals, by the State Department of Health Services. Existing law specifically provides that, before the department approves a downgrade or closure of emergency services, it is required to review a county impact evaluation that determines the impacts of the downgrade or closure on the community, as specified.

Under existing law, a hospital that provides emergency medical services is required to provide notice to the State Department of Health Services and to other specified entities, within 90 days before a planned reduction or elimination of the level of these services, and also to provide notice of the intended change to the public, except under

specified circumstances. Existing law also requires a health facility implementing a downgrade or closure to make reasonable efforts to inform the affected community of the change.

This bill would establish the Hospital Community Responsibility Act. The bill would require, except for public hospitals, as defined, that, before approving a downgrade or closure of a hospital or emergency service, the department shall receive a copy of a hospital protection review (HPR) from the county in which the hospital or emergency service is located. The bill would require the county board of supervisors to appoint a hospital protection committee (HPC), with specified membership, to review the HPR. The bill would require a hospital to give 120 days notice before a proposed downgrade or closure, and would require the HPR to be completed within 60 days, and to incorporate one or more public meetings. The bill would require the HPR to include a thorough review of the impact of the downgrade or closure on the community. This bill would require the HPC to hold a hearing to release the results of the HPR, including the HPC's recommendations for mitigation, to specified entities no less than 45 days before the scheduled downgrade or closure, if the HPR reveals that the capability of the community's health care delivery system would be detrimentally affected by the downgrade or closure. The bill would provide that these procedures would be in addition to the notice required under existing law. The bill would require the hospital to pay the board of supervisors for contract costs and other specified costs related to the development of the HPR. Because it imposes new duties on counties, this bill would impose a state-mandated local program.

This bill would also prohibit any person, commencing January 1, 2004, from obtaining or continuing to possess an ownership interest, as defined, in more than one licensed hospital within the same county, or in any geographic area within a 25-mile radius, regardless of county boundaries, unless that person obtains the approval of the Attorney General and enters into a Community Responsibility Contract (CRC) pursuant to the bill. The bill would require the Attorney General, in consultation with the department and the Office of Statewide Health Planning and Development, to establish related regulations, as well as the specific terms of the CRC and initial approval criteria for multiple hospital ownership. The bill would provide that these provisions shall not apply to a public hospital, as defined. The bill would require the person or entity seeking the CRC, or the entity selling or acquiring a hospital, as appropriate, to pay the Attorney General for contract costs,

and other specified costs related to the development and monitoring of the CRC pursuant to the requirements of the bill.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known and may be cited as the Hospital Community Responsibility Act.

SEC. 2. Section 1255.1 of the Health and Safety Code is amended to read:

1255.1. (a) Any hospital that provides emergency medical services under Section 1255 shall, as soon as possible, but not later than 90 days prior to a planned reduction or elimination of the level of emergency medical services, provide notice of the intended change to the state department, the local government entity in charge of the provision of health services, and all health care service plans or other entities under contract with the hospital to provide services to enrollees of the plan or other entity. The notice required by this section shall be in addition to the procedures required by Chapter 1 (commencing with Section 130500) of Division 112.

(b) In addition to the notice required by subdivision (a), the hospital shall, within the time limits specified in subdivision (a), provide public notice of the intended change in a manner that is likely to reach a significant number of residents of the community serviced by that facility.

(c) A hospital shall not be subject to this section or Section 1255.2 if the state department does either of the following:

(1) Determines that the use of resources to keep the emergency center open substantially threatens the stability of the hospital as a whole.

(2) Cites the emergency center for unsafe staffing practices.

SEC. 3. Section 1300 of the Health and Safety Code is amended to read:

1300. (a) Any licensee or holder of a special permit may, with the approval of the state department, surrender his or her license or special permit for suspension or cancellation by the state department. Any license or special permit suspended or canceled pursuant to this section may be reinstated by the state department on receipt of an application showing compliance with the requirements of Section 1265.

(b) (1) Before approving a downgrade or closure of emergency services pursuant to subdivision (a), the state department shall receive a copy of the impact evaluation of the county to determine impacts, including, but not limited to, an impact evaluation of the downgrade or closure upon the community, including community access to emergency care, and how that downgrade or closure will affect emergency services provided by other entities. Development of the impact evaluation shall incorporate at least one public hearing. The county in which the proposed downgrade or closure will occur shall ensure the completion of the impact evaluation, and shall notify the state department of results of an impact evaluation within three days of the completion of that evaluation. The county may designate the local emergency medical services agency as the appropriate agency to conduct the impact evaluation. The impact evaluation and hearing shall be completed within 60 days of the county receiving notification of intent to downgrade or close emergency services. The county or designated local emergency medical services agency shall ensure that all hospital and prehospital health care providers in the geographic area impacted by the service closure or change are consulted with, and that local emergency service agencies and planning or zoning authorities are notified, prior to completing an impact evaluation as required by this section. This subdivision shall be implemented on and after the date that the county in which the proposed downgrade or closure will occur, or its designated local emergency medical services agency, has developed a policy specifying the criteria it will

consider in conducting an impact evaluation, as required by subdivision (c).

(2) This subdivision shall only apply to a public hospital that is not subject to the hospital protection review process required pursuant to Chapter 1 (commencing with Section 130500) of Division 112. This subdivision does not apply to a private hospital.

(c) The Emergency Medical Services Authority shall develop guidelines for development of impact evaluation policies. On or before June 30, 1999, each county or its designated local emergency medical services agency shall develop a policy specifying the criteria it will consider in conducting an impact evaluation pursuant to subdivision (b). Each county or its designated local emergency medical services agency shall submit its impact evaluation policy to the state department and the Emergency Medical Services Authority within three days of completion of the policy. The Emergency Medical Services Authority shall provide technical assistance upon request to a county or its designated local emergency medical services agency.

SEC. 4. Division 112 (commencing with Section 130500) is added to the Health and Safety Code, to read:

DIVISION 112. HOSPITAL COMMUNITY RESPONSIBILITY

CHAPTER 1. HOSPITAL PROTECTION REVIEW

130500. (a) (1) Notwithstanding any other provision of law, the procedures established by this section shall apply to the downgrade or closure of a hospital, including the downgrade or closure of a hospital that provides emergency medical services under Section 1255, except that this section shall not apply to a public hospital, as defined in paragraph (25) of subdivision (a) of Section 14105.98 of the Welfare and Institutions Code.

(2) For purposes of this chapter, a downgrade includes any instance in which a hospital ceases to operate an emergency medical service, or any other acute inpatient medical or surgical service listed on its initial application, or renewal application, including, but not limited to, medical, surgical, therapeutic, and diagnostic services.

(b) (1) Before approving a downgrade or closure of a hospital or emergency service, the department shall receive a copy of the hospital protection review (HPR) required by this section.

(2) Notice of the proposed downgrade or closure shall be submitted to the department and the board of supervisors at least 120 days before the proposed date of the downgrade or closure.

(3) The board of supervisors in the county in which the hospital or emergency service is located shall require the performance of the HPR, which shall include a thorough review of the impact of the downgrade or closure of the hospital or emergency service on the community. This review shall include all of the following:

(A) A comprehensive financial disclosure that helps explain the change in hospital care service.

(B) A determination of the ability to treat medical emergencies of patients from communities surrounding the hospital.

(C) A determination of the impact of the downgrade or closure on other surrounding hospitals.

(D) An assessment of the overall impact that the downgrade or closure has on the uninsured, the elderly, children, and various other groups that may be adversely affected in the service area of the hospital.

(E) An assessment of the overall impact that the service change or closure will have on the capability of the health care delivery system to serve each surrounding community.

(4) The HPR shall be reviewed by a hospital protection committee (HPC), convened by the board of supervisors. The HPC shall consist of the following nine members:

(A) Two members nominated by an organization representing the majority of acute care hospitals in the county.

(B) Two members nominated by organizations representing hospital workers.

(C) Two members nominated by organizations representing physicians and surgeons.

(D) Three members selected by the board of supervisors, two of whom shall be representatives of nonprofit organizations that, at least in part, represent medically uninsured and low-income residents of the community, and one of whom represents health care consumers in the community.

(5) The board of supervisors shall designate one committee member to serve as chair.

(6) For purposes of subparagraphs (A), (B), and (C) of paragraph (3), the board of supervisors shall request nominations from organizations that the board determines are most representative of the specified categories.

(c) (1) The HPR shall be completed within 60 days of notice of the proposed downgrade or closure.

(2) During the development of the HPR, the hospital protection HPC shall conduct one or more public meetings to hear comments from interested parties. At least 14 days prior to the public meeting, the HPC shall provide written notice of the time and place of the meeting through publication in one or more of the newspapers of general circulation in the county.

(3) If the HPR reveals that the capability of the community's health care delivery system would be detrimentally affected by the downgrade or closure, the HPC shall make recommendations to mitigate the detrimental impact, and shall make these recommendations available to the board of supervisors, the department, the Legislature, and the public, in order to attempt to preserve services deemed necessary pursuant to the HPR. These recommendations shall include, but shall not be limited to, all of the following:

(A) Recommendations for solutions for the community to deal with possible financial troubles impacting the hospital.

(B) Recommendations to the community to mitigate the impact of the service change or closure on the ability to treat emergencies of patients from surrounding communities of the hospital.

(C) Recommendations to the community to mitigate the impact of the service change or closure on the uninsured, the elderly, children, and other adversely affected groups in the service area of the hospital.

(D) Recommendations to the community to mitigate the impact of the service change or closure on the capability of the health care delivery system to serve the surrounding community.

(3) The HPC shall conduct a public hearing to release the results of the HPR, including any recommendations required by this subdivision, no less than 45 days before the scheduled downgrade or closure. This hearing shall be in addition to the hearings required by paragraph (1). If a substantive change in the closure or downgrade is proposed to the board after the public

hearing, the HPC may conduct an additional public meeting to hear comments from interested parties.

(d) For purposes of this section, ''hospital'' means a general acute care hospital.

(e) (1) Within the time periods specified in this section and relating to the factors specified in this chapter, the board of supervisors may do the following:

(A) Contract with, consult, and receive advice from, any state agency, on those terms and conditions that the board deems appropriate.

(B) In its sole discretion, contract with experts or consultants to assist in reviewing the proposed agreement or transaction.

(2) Contract costs pursuant to this section may not exceed an amount that is reasonable and necessary to conduct the review and evaluation. Any contract entered into pursuant to this section shall be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. The hospital, upon request, shall pay the board promptly for all contract costs.

(3) The board shall be entitled to reimbursement from the hospital for all actual, reasonable, direct costs incurred in reviewing, evaluating, and making the determinations referred to in this chapter, including administrative costs. The hospital, upon request, shall pay the board promptly for all of these costs.

(4) The board may require the entity required to make reimbursement under paragraph (2) or (3) to make immediate payments for costs when they are incurred under the contract or may reasonably be expected to be incurred under the contract, when the board determines that the payment is necessary to ensure implementation of the contract without incurring unsupported cost payments by the board in the implementation of the contract.

CHAPTER 2. COMMUNITY RESPONSIBILITY CONTRACTS

130510. (a) (1) Commencing January 1, 2004, no person shall obtain an ownership interest in more than one hospital licensed under this chapter within the same county, or in any geographic area within a 25-mile radius, regardless of county boundaries, unless that person first obtains the approval of the

Attorney General and enters into a Community Responsibility Contract (CRC) with the Attorney General pursuant to this section.

(2) Any person in possession of an ownership interest in more than one licensed hospital within the same county, or in any geographic area within a 25-mile radius, regardless of county boundaries, on January 1, 2004, shall enter into a CRC pursuant to this section by January 1, 2005.

(3) The Attorney General may approve, conditionally approve, or deny approval to a CRC in accordance with this chapter.

(b) (1) The purpose of the CRC shall be to minimize market concentration that may increase the prices paid for hospital services by purchasers of health services and purchasers of health coverage, and that does not demonstrably improve the availability, accessibility, or quality of health services available to the community. The Attorney General, in consultation with the Office of Statewide Health Planning and Development and the State Department of Health Services, shall develop regulations for the establishment of CRCs in accordance with this chapter.

(2) The Attorney General shall also establish the specific terms of the CRC, as well as initial approval criteria for multiple hospital ownership. In establishing the terms of each CRC, the Attorney General shall consider any factors he or she deems relevant, including, but not limited to, whether the CRC does both of the following:

(A) Provides community protections to ensure planning and management of hospitals to provide fair competition within the community, the region, and the state with respect to prices paid by purchasers of health services and purchasers of health coverage, and to ensure availability, accessibility, and quality of health services available to the community.

(B) Provides sufficient financial disclosure in service changes or closures, to determine whether those changes or closures are consistent with the purposes of this chapter.

(c) This section shall not apply to a public hospital, as defined in paragraph (25) of subdivision (a) of Section 14105.98 of the Welfare and Institutions Code.

(d) For purposes of this section, ‘‘ownership interest’’ does not include any financial interest in or security issued by a business entity, including, but not limited to, common stock, preferred stock, rights, warrants, options, debt instruments, and any

partnership or other ownership interest owned directly, indirectly, or beneficially by the person or his or her immediate family, that equals less than 10 percent of the value of the business entity.

(e) (1) With respect to the factors specified in this chapter relating to the development of the CRC, the Attorney General may do all of the following:

(A) Contract with, consult, and receive advice from, any state agency, on those terms and conditions that the Attorney General deems appropriate.

(B) In his or her sole discretion, contract with experts or consultants to assist in reviewing the proposed agreement or transaction.

(2) The Attorney General, in his or her sole discretion, may contract with experts and consultants for assistance in order to effectively monitor ongoing compliance with the terms and conditions of any CRC, including, but not limited to, the ongoing impact of market concentration on prices paid by purchasers, and the availability, accessibility, and quality of health services.

(f) (1) Contract costs pursuant to this section shall not exceed an amount that is reasonable and necessary to conduct the review and evaluation. Any contract entered into pursuant to this section shall be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. The person or entity seeking the CRC shall pay the Attorney General promptly for all contract costs.

(2) (A) The Attorney General shall be entitled to reimbursement from the person or entity seeking the CRC for all actual, reasonable, direct costs incurred in reviewing, evaluating, and making the determinations required by this chapter, including administrative costs. The person or entity seeking the CRC, upon request, shall pay the Attorney General promptly for all of these costs.

(B) The Attorney General shall be entitled to reimbursement from either the selling or the acquiring entity, depending upon which entity the burden of compliance falls, for all actual, reasonable, and direct costs incurred in monitoring ongoing compliance with the terms and conditions of the CRC, including contract and administrative costs. The Attorney General may bill

either the selling or the acquiring entity and the entity shall pay the Attorney General promptly for all of those costs.

(C) The Attorney General may require the entity required to make reimbursement under subparagraph (A) or (B) to make immediate payments for costs when they are incurred under the contract or may reasonably be expected to be incurred under the contract, when the Attorney General determines that the payment is necessary to ensure implementation of the contract without incurring unsupported cost payments by the Attorney General in the implementation of the contract.

SEC. 5. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.

O